Contract to Provide Health Management Services
Supplementary Agreement
Between
The Department of Human Services, Medical Services Division (North Dakota Medicaid)
and

_____

Clinic/Provider Name (Please Print or Type)

_____

North Dakota Medicaid ID Number

This agreement is entered into between the ND Department of Human Services, Medical Services Division, hereinafter referred to as "the Department", and the above-named Clinic or Provider, hereinafter referred to as a "Health Management Team", whose address/location is:

(Address) _____

(City) _____ (State) _____ (Zip Code) _____

(Phone) _____ (Medicaid Provider ID Number) _____

Section I. General Statement of Purpose and Legal Authority

The Department contracts with Health Management Team, which participates in the North Dakota Medicaid Program to provide health management (HM) services to certain Medicaid recipients with the following chronic conditions: Asthma, Diabetes, Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF). This agreement describes the terms and conditions under which the agreement is made and the responsibilities of the parties thereto.

This agreement shall be construed as supplementary to the provider agreement entered into by all providers participating in the North Dakota Medicaid Program, and all provisions of that agreement shall remain in full force and effect, except to the extent superseded by the specific terms of this agreement. The provider agrees to abide by all existing laws, regulations, rules and procedures applicable to the North Dakota health management program and North Dakota Medicaid participation.

Section II. Definitions

Care Coordinator means a person with primary care experience whose responsibilities include proactively managing and coordinating care for the health management participant throughout the continuum of care; works closely with the primary care provider(s), health team members, other health care professionals, family members, internal and external services, and community

agencies; facilitates access to the Health Management Team, resources and services; and ensures that progress is being made as appropriate.

Care Coordination means a team approach in coordinating a full range of medical services and social supports across different organizations and providers (Rosenbach & Young, 2000).

Chronic Condition is a condition which has lasted at least six months, can reasonably be expected to continue at least six months, or is likely to recur.

Cold-Call Marketing means any unsolicited personal contact by the Health Management Team with a potential enrollee for the purpose of marketing as defined in this section.

Dual Eligibility means individuals who are entitled to Medicare Part A or Part B and are eligible for some form of Medicaid benefit.

Health Management Eligible Participant means being Medicaid eligible during the month HM benefits are delivered, having been diagnosed with Asthma, Diabetes, CHF or COPD, having one of the qualifying conditions meeting the definition of "chronic condition", and not possessing any exclusion during the month of HM services. Exclusions for participation in the program consist of: dual eligibility, recipient liability, additional major medical coverage (third party liability), residing in a nursing facility or intermediate care facility for the intellectually disabled (ICF/ID) and receiving health management services from another source (see reimbursement Section VII for further information on exclusions).

Marketing means any communication from a Health Management Team to a Medicaid recipient who is not enrolled in that entity, that can reasonably be interpreted as intended to influence the recipient to enroll in that particular Health Management Team's Medicaid product, or either to not enroll in, or to disenroll from another health management Medicaid product.

Participant means a Medicaid recipient, meeting the criteria of the health management program and providing written or verbal consent, documented in the participant's care plan, medical record or intake system, to participate in the HM program.

Primary Care means all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

Recipient means a person eligible for Medicaid benefits.

Section III. Scope of Service

Health Management Team will provide health management services utilizing Department approved evidence based clinical guidelines from recognized sources. Health Management Team has a process in place to review its clinical practice guidelines (at a minimum) every two years or when significant new findings become available. This includes a review of any participant and provider content, organizational training materials and curricula, web-based materials, verbal scripts, and any other materials relating to the program to ensure they are up to date and consistent with the current practice guidelines. As significant new findings become available in relation to the evidence based guidelines, Health Management Team must review the findings and adopt them, as appropriate. Changes to the guidelines must be submitted for approval by the Department.

Health Management Team provides for a system of care coordination efforts which must include (at a minimum) the following participant and provider services and support:

1. Designated health care team (practitioner, care coordinator and other staff as appropriate considering the patient's needs and diagnosis). This includes the organizational structure of the team and an explanation of how this team functions, communicates, and incorporates the patient and family in providing health management services.

2. Designated practitioner or provider who oversees the health management program, and approves the evidence based guidelines utilized by the health team.

3. Designated care coordinator(s) within the health care team.

4. Established, systematic screening process to identify eligible Medicaid participants who qualify for and would benefit from the health management program. The screening process should provide the basis in which to identify interventions and service intensity based on patient needs or risk level (which may include but is not limited to: co-morbidities and other health conditions, adherence to treatment plan, depression screening and screening results, health behaviors and psychosocial issues).

5. Coordinate, communicate and integrate local service systems and supports by building collaborative relationships with local social and community and state service agencies. Local state and county services should be utilized if available.

6. Provide assistance to participants with information related to local social, state and community based, free care initiatives and support groups. This should include information and assistance in order to successfully navigate the health care system.

7. Develop individualized care plans as appropriate (to include identifying needs, implementation and evaluation) in collaboration with the participant, family (if appropriate), and personal primary care provider. A care plan policy should define and guide which participants should have a care plan and the elements that must be included in the care plan.

8. Provide education to enhance the participant's understanding as well as the appropriate management of the participant's condition(s). This includes education about self-management, appropriate use of resources, how to navigate the health care system, and how the care coordinator will work with the participant and their primary care provider to promote and coordinate the plan of care.

9. Provide participants with continuous, toll-free access to a health team member/ designated clinic staff, or on-call provider, or a toll-free, phone triage system 24 hours per day, seven days per week, and 365 days per year.

    a. The designated clinic staff, on-call provider, or phone triage system representative has continuous access to the participant's health record information. The health record information must include information in which the designated clinic staff, on-call provider, or phone triage system representative is able to determine when scheduling an appointment for the participant is appropriate.

    b. The application of a protocol that addresses whether to schedule an appointment within one business day to minimize emergency room visits and hospitalizations.

10. Established systematic intake system or participant registry which must record (at a minimum) the following data for each participant: name, Medicaid ID number, age, gender, racial or ethnic background, preferred language, vision and/or hearing needs, preferred method of communication, participant contact information, and primary care provider.

11. Document various elements of care coordination in the participant's care plan or medical record (taking into consideration data types to which it has access to such as claims, medical records, or participant self-reported information). These elements should assist and guide the Health Management Team in implementation of the medical plan:

    a. Identification of participant's chronic condition: Asthma, Diabetes, CHF, COPD,
    b. Dates of previous and upcoming clinical appointments,
    c. Contact history log,
    d. Self-management goal tracking,
    e. Treatment plan and participant adherence to plan,
    f. Co-morbidities and other health conditions,
    g. Health behaviors and psychosocial issues,
    h. Schedule for follow-up contacts,
    i. Referrals for specialty care, whether and when the participant has been seen by a provider to whom a referral was made, and the result of the referral,
    j. Test orders, when test results have been received and communicated to the participant,
    k. Admissions to hospitals or skilled nursing facilities and the result of the admission,

l. Timely post-discharge planning according to a protocol for participants discharged from the hospitals, skilled nursing facilities, or other health care institutions,
m. Communication with participant's pharmacy regarding use of medication and medication reconciliation, and
n. Other information as needed that may benefit the care coordination for the participant.

12. Conduct pre-visit preparations or reminders for recall visits. This may be in the form of letters, questionnaires or telephone calls which elicit information such as: reason for visit, medication changes, changes in health since last appointment, emergency department usage since last appointment, preventive care, planned return to clinic appointments, concerns to be discussed during appointment, and knowledge of care coordinators availability.

13. Conduct follow up with participants who have not kept appointments.

14. Provide written introductory information (in the form of a letter, brochure, or information packet). These must be supplied to the participant upon enrollment. Brochures/materials must be distributed to the Department, providers, and agencies as requested. The materials must include (at a minimum) the following:

    a. Description of the health management program.
    b. Explanation of the health management benefits to include information stating the program is voluntary and the participant may disenroll at any time.
    c. Description of how to access a care coordinator or health team member to include day, evening, and weekend contact information.
    d. Description of participant rights and responsibilities, including how to file a grievance or complaint, and information on the organization's confidentiality policy.
    e. Must not seek to mislead, confuse, or defraud the participant (42 §CFR 438.104(b)(2)).

    All materials are subject to approval by the Department including all revisions and updates (42CFR §CFR 438.104(b)(1)(i)).

15. Obtain participant input which may be in the form of surveys, questionnaires, or focus groups.

17. Provide and make available advance preparations in the utilization of interpreter services for communication, care planning and education for each non-English speaking participant. This may be accomplished by coordination through local county social service offices.

18. Participants must been seen by a Health Management Team licensed practitioner or provider yearly, at a minimum, in relation to their chronic condition.

19. Establish adequate information, consents, or authorizations as well as privacy and security measures required by HIPAA, Medicaid confidentiality, and any other federal and state laws.

Health Management Team will implement a Quality Management and Improvement program and Grievance Process. This will include the following:

1. Develop and implement Quality Management (QM) oversight that incorporates initiatives, strategies, staff time and organization, methodologies for on-going quality assurance, quality improvement, and performance assessment activities.

2. Identify a qualified, key individual to be responsible for the operation and success of the quality management program.

3. Provide a written description of the QM program, including program structure and processes. These structures and processes must be submitted for approval by the Department.

4. Study and evaluate issues that the Department may identify periodically.

5. Establish participant surveys (subject to approval by the Department).

6. Develop a training plan for staff which includes documentation of completed training and attendance log. This must be submitted to the Department on a semi-annual basis.

7. Develop a Grievance policy to handle any grievances or complaints by participants. This policy must address how Health Management Team will handle grievances, time frame for responding, addressing the grievance and developing a reporting log. The log will include date of grievance, who submitted the grievance (i.e. participant, family member), result/remedy of the grievance, time-frame for responding to the grievance, and quality management and improvement changes or activities which resulted from the grievance. The grievance policy is subject to approval by the Department. The grievance log will be submitted to the Department on a quarterly basis.

8. Establish adequate information, consents or authorizations as well as privacy security measures required by HIPAA, Medicaid confidentiality, and any other federal and state laws.

Section IV. Health Management Services (General Terms and Conditions)

1. Be a North Dakota Medicaid enrolled provider.

2 Comply with all applicable Federal and State laws and regulations.

3. Do not discriminate on the basis of health status or need for health care services.

4. Do not discriminate against individuals enrolled on the basis of race, color, gender, age, disability, or national origin. Health Management Team will not use any policy or practice that has the effect of discriminating on the basis of race, color, gender, age, disability, or national origin.

5. Health Management Team may disenroll or terminate the HM Team-Participant relationship by providing 30 days written notice to the recipient and to the Department. Reason for the termination must be considered "good cause" as outlined in the *Managed Care* chapter of the *General Provider Manual.* These reasons must be explained in writing, be non-discriminatory, and generally applied to Health Management Team's entire participant base, and approved by the Department.

6. Health Management Team agrees not to distribute any marketing materials without first obtaining approval from the Department.

7. Health Management Team agrees not to directly or indirectly engage in door-to-door, telephone, or other cold-call marketing activities.

8. Health Management Team agrees to provide potential participants with accurate oral and written information he or she needs to make an informed decision on whether to enroll.

9. Health Management Team agrees not to seek to influence the recipient to not enroll in or to disenroll from another Health Management product.

Section V. Reports

Reports are due 45 days after the end of a reporting period. Quarterly reports will reflect the following schedule: January 1-March 31, April 1-June 30, July 1-August 31, and October 1-December 31. Semi-annual reports will reflect January 1-June 30 and July 1-December 31. The report for the last quarter of the contract period (i.e., October 1 – December 31) must be submitted by January 15 (after the end of the contract period).

Reports will be submitted electronically to the Department through secure file transfer protocol. Reporting activities are subject to change at the Department's discretion. Payment to the Health Management Team is contingent upon the Department's receipt of specified reports on schedule; late or insufficient reports will result in the Department withholding payment until adequate reports are received. Reporting requirements are subject to change at the Department's discretion.

See Attachment A for the required reports.

See Attachment B for the required format.

Section VI. Program Evaluation and Oversight

1. The Department may conduct on-site reviews and may request additional documentation prior to and during the operation of the health management program.

2. A program evaluation process will be completed by the Department's data analytic vendor. Program evaluation will begin immediately upon program implementation and continue through the length of the program. Health Management Team will be required to collect and submit the program data necessary to meet the needs of the defined evaluation process and any other data requested by the Department.

3. Health Management Team shall cooperate with the Department and its data analytic vendor in conducting external evaluations by providing requested data and information as needed.

4. Health Management Team will be required to submit additional information to assist the Department with rate setting for the HM program. The type of information that will be needed may include time spent on case management activities and other related activities.

Section VII. Reimbursement

1. The parties agree that Health Management Team shall be reimbursed as follows:

    a. Health Management Team will be reimbursed per qualified Medicaid eligible member/per month as provided in the fee schedule.
    b. Recovery of health management fees is at the discretion of the Department.

2. Reimbursement will only be made for those enrollees:

    a. That are Medicaid eligible for the month and are receiving health management services.
    b. That do not possess any of the following exclusions during the month services are received:

        i. Dual Eligible;
        ii. Recipient Liability;
        iii. Other Major Medical Coverage (TPL);
        iv. Resides in a nursing facility or intermediate care facility for the intellectually disabled (ICF/ID);
        v. Enrolled with another Health Management Provider (only one Medicaid enrolled Health Management provider/clinic/DMO will be reimbursed for a member monthly. Duplicative payments for the same member will not be reimbursed within the same month).

c. That have a signed a written agreement or provided verbal consent (which is documented in the participant's plan of care or registry system) to participate in the health management program.
d. That have been diagnosed by a licensed provider (within their scope of practice) as having one (or more) of the four following conditions:

   i. Asthma
   ii. Diabetes
   iii. Chronic Obstructive Pulmonary Disease
   iv. Congestive Heart Failure

e. That has a condition (Asthma, Diabetes, COPD, or CHF) that is chronic.

3. Health Management Team must submit a claim, per eligible participant/per month by either submitting a paper CMS-1500 claim form or a HIPAA compliant 837 electronic claim transaction.

   The Health Management Team will bill with the date of service spanning the entire month. Only one service per month can be billed for each individual participant.

   HCPCS code S0280 will be billed for the Initial Care Coordination visit ONLY.

   HCPCS code S0281 will be billed for each additional month of service.

   Modifiers MUST be included with each HCPCS code and would be billed for each chronic condition as follows:

   Modifier U4: Asthma
   Modifier U5: CHF
   Modifier U6: COPD
   Modifier U7: Diabetes

Section VIII. Sanctions

Sanctions are listed per the *General Information for Providers-Medicaid and Other Medical Assistance Programs* Manual, *Managed Care* Chapter. Sanctions can be imposed per North Dakota Administrative Code Chapter 75-02-05.

Section IX. HIPAA

The Health Management Team must establish adequate consents/authorizations, information and privacy security measures to comply with HIPAA requirements and other federal and state laws.

Section X. Fraud and Abuse

Report any possible instances of Medicaid fraud to the Department immediately upon receipt of information.

Section XI. Termination from Participation

1. This agreement may be terminated by either party by providing written notice 30 days in advance of the desired date of termination or removal. The 30 days will allow participants time to select another health management provider.

2. The Department may terminate the agreement immediately upon written notice to Health Management Team when such termination is considered to be in Medicaid's best interest to assure the continuation of necessary and appropriate service to Medicaid recipients.

Signature of Health Management Team Representative	Title	Date

Signature of North Dakota Medical Services Representative	Title	Date